ADIRONDACK CENTRAL SCHOOL
STUDENT HEALTH INFORMATION FORM
2016-2017

Please PRINT LEGIBLE all information using blue or black ink.

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STUDENT INFORMATION: ☐ Male ☐ Female Grade ________ Teacher (Elementary Only): ____________________

Last Name: ________________________________First Name: __________________________Middle Name: ___________________

Date of Birth: ______________Home Phone Number: ______________Bus Number: a.m. run ___________ p.m. run ___________

Mailing Address____City: ____________________State: ______ Zip: _________

911 Address____City: ____________________State: ______ Zip: _________

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PARENT/GUARDIAN INFORMATION:

Child Lives With: ☐ Mother ☐ Father ☐ Both Parents ☐ Other, please specify: ______________________________
Child's Legal Guardian: ☐ Mother ☐ Father ☐ Shared Custody ☐ Other, please specify: ______________________________
Parent's Current Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Remarried ☐ Separated

Parent/Guardian 1: (If you'd like more than 2 parents listed, please use a separate sheet of paper):
Name: ____ Relation to Student: ________________________________
Residential Address: ____ City: ____________________________ Zip: __________
Parent Mailing Address: ____ City: ____________________________Zip: ___________
Phone Numbers: Home________________Work: _______________Cell: ______________ Receive Mailings? ☐ Yes ☐ No
Employer: ____
E-Mail______________________________________ Are you allowed to pick up student? ☐ Yes ☐ No
Are you in the Armed Forces? ☐ Yes ☐ No If yes? Branch? _________________________ Location?____________________

Parent/Guardian 2:
Name: ____ Relation to Student: ________________________________
Residential Address: ____ City: ____________________________ Zip: __________
Parent Mailing Address: ____ City: ____________________________Zip: ___________
Phone Numbers: Home________________Work: _______________Cell: ______________ Receive Mailings? ☐ Yes ☐ No
Employer: ____
E-Mail______________________________________ Are you allowed to pick up student? ☐ Yes ☐ No
Are you in the Armed Forces? ☐ Yes ☐ No If yes? Branch? _________________________ Location?____________________

Names of Brothers and Sisters (If more space is needed, please use a separate sheet of paper):
Sibling 1: Name: ____ Date of Birth ___/___/___ Grade: ___
Address (if not the same) ____ City: __________________ State: _____ Zip: ______
Sibling 2: Name: ____ Date of Birth ___/___/___ Grade: ___
Address (if not the same) ____ City: __________________ State: _____ Zip: ______
Sibling 3: Name: ____ Date of Birth ___/___/___ Grade: ___
Address (if not the same) ____ City: __________________ State: _____ Zip: ______

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PERMISSION TO SIGN OUT:

A student may be released to either parent unless a custodial parent supplies the school principal with a certified copy of a court order or divorce decree to the contrary. No student may be released from school to anyone other than the parent/guardian unless the parent/guardian has informed the school with a note. ***Our automated call system is used during emergency situations such as but not limited to: early dismissal, snow days, snow delays, etc. Please check whether you'd like to be notified by this system.***

EMERGENCY CONTACT INFORMATION - ***Those designated below are authorized to pick up student in case of an emergency. Please use an additional sheet of paper if you'd like to include more contacts.***

Name____ Relationship: _______________________________Home Phone___________
Work #____________________ Cell #________________ **Automated Call System Notification** ☐ **Yes** ☐ **No**

Name____ Relationship: _______________________________Home Phone___________
Work #____________________ Cell #________________ **Automated Call System Notification** ☐ **Yes** ☐ **No**

Name____ Relationship: _______________________________Home Phone___________
Work #____________________ Cell #________________ **Automated Call System Notification** ☐ **Yes** ☐ **No**
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MEDICAL / PHYSICIAN INFORMATION

Please indicate any health conditions which may affect classroom performance, attendance, or limit physical activity.

Explanation: ____
List child's allergies or medical conditions: ____
Medication(s) student is currently taking: ____
Reason for taking medication: ____
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I would like school personnel to be aware of his/her medical condition: ☐ Yes ☐ No

Doctor's Name: ____ Phone #_________________________

Dentist's Name: ____ Phone #_________________________

Hospital preference____

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Is there anything we should be aware of that may affect your child's performance in school, such as a death in the family or separation?
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By signing below:

1. I understand that the Adirondack Central School District will release my child to his/her other parent/guardian without my consent, unless I provide the District with a court order or other legally binding document that restricts the other parent/guardian's authority to obtain the release of my child.
2. I understand that the Adirondack Central School District does not have the power to independently gather court orders or other legally binding documents that affect the custody of my child. Therefore, it is my responsibility to provide the District with the most recent court order or other legally binding document that affects the custody of my child.
3. I authorize the District to release my child to the people listed above in the Emergency Contact Information section of this document and/or to contact them in case of an emergency.
4. All of the information contained here is needed as a permanent school record of your child and will be used by school personnel. This is to certify the above information is correct. I, the undersigned, do hereby authorize officials of the school to contact directly the person named on this form, and do authorize the above named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event the physician, other person named on the form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent/Guardian Signature: ______________________________________ Date: ____________________

Parent/Guardian Signature: ______________________________________ Date: ____________________

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LIVING SITUATION:

Complete this section only if it reflects your child's current living condition or if you are a youth not living with a parent or guardian. Your answer will help school personnel accurately report data and may enable the student to receive additional services according to the McKinney-Vento Homeless Assistance Act of 2002. Check one box if you are living:

☐ In a shelter
☐ In a park or a car
☐ In an abandoned apartment/building
☐ Temporarily housed in a shelter awaiting a DCFS permanent foster placement
☐ With relatives or others due to lack of housing
☐ In a camp ground, or other situation due to the lack of adequate housing

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Please fill out one form for each student and return **as soon as possible** to the main office.

Contact the building secretary immediately if any information changes.